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A Qualitative Investigation of Former Clients' Perception of Change, Reasons for Consultation, Therapeutic Relationship, and Termination

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The purpose of this research is to investigate former client's perception of change, reasons for consultation, therapeutic relationship, and termination. Semistructured interviews were conducted with 17 former clients who had been in a psychotherapeutic treatment. A qualitative approach, based on consensual qualitative research (CQR) was used to analyze the interviews. Results show how the balance of negative and positive aspects of the therapeutic relationship is associated with the perception of change. Likewise, categories related to reasons for consultation were associated with types of change and therapy termination. The relevance of the client's perspective is increasingly being recognized as valuable for the understanding of the psychotherapeutic processes and generates hypotheses for future research.

Keywords: change process, client's perception, therapeutic relationship

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Change assessment and its characterization has been a central concern for psychotherapy research from its beginning. Several studies have explored how clients perceive change and how they relate that change to different elements of the therapeutic process (e.g., Hill et al., 2011; Klein & Elliott, 2006; Levitt, Butler, & Hill, 2006; Mendes et al., 2010). However, it is essential to continue pursuing the client's perception to deepen our understanding of the interaction of the elements of the therapeutic process and change perception.

Clients' perspectives of therapeutic outcome was the first strategy used to assess change in the early thirties (Kächele, 1992). Later, many researchers pursued objectivity by making use of therapists' observation, external raters, or information from significant others about the clients' change (Smith, Hilsenroth, Baity, & Knowles, 2003). This approach multiplied the sources of information about change and outcome in psychotherapy. Recently, clients' views have reemerged as a valuable way of assessing change perception (e.g., Foskett, 2001; Gordon, 2000; Heatherington, Constantino, Friedlander, Angus, & Messer, 2012; Klein & Elliott, 2006; Krause, 2005; Manthei, 2007).

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Change Process Research Methodology

Elliott (2010), describing the actual state of change process research, mentions three methodological approaches: quantitative process outcome, qualitative helpful factors, and microanalytic sequential process. The integration of these approaches allows a better comprehension of the change process. From Elliot's perspective, qualitative methods consistent with the "ask the client" movement, are an empowering tool to explore clients' change in psychotherapy (Elliott, 2010). While scales such as OQ45 provide the participant with a list of options that they have to stick to, in-depth interviews allow them to express anything that they think about their change and this might bring new perspectives that researchers have not thought about (Kazdin, 1999). As Elliott (2010) mentions, the qualitative helpful factors approach has special appeal for those who want to examine in detail the opinion of the consumers of psychotherapy.

There is evidence that therapists and clients do not necessarily agree on change or outcome of psychotherapy (Bryan, Dersch, Shumway, & Arredondo, 2004; Henkelman & Paulson, 2006; Manthei, 2006; Viklund, Holmqvist, & Zetterqvist Nelson, 2010), and most research in psychotherapy has been performed from the therapists' point of view (Foskett, 2001; Henkelman & Paulson, 2006). Horvath (2000), in the paradigmatic case of therapeutic alliance, sustains that clients' subjective assessment of their therapeutic relationship has more impact on outcome than therapists′ actual behavior. Kazdin (1999) sustains the importance of including the clients' experience in the criteria for psychotherapy appraisal. Following Kazdin′s idea (1999), the present study aims to address clients' subjectivity to add new information on the process of change by exploring what clients' perceive of their own change.

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Clients' Perception

There are different approaches to the clients' point of view. There are studies that describe the perception the client has of his or her psychopathology (Poulsen, Lunn, & Sandros, 2010). Other researchers are interested in clients' point of view of their treatment as a whole, by addressing helpful and hindering aspects (Bowman & Fine, 2000; Castonguay et al., 2010; Israel, Gorcheva, Burnes, & Walther, 2008; Levitt et al., 2006; Paulson, Truscott, & Stuart, 1999). There are also those who engage in specific aspects of therapy, such as the therapeutic alliance (Audet & Everall, 2010; Bachelor, 1991), or a singular theoretical framework (Midgley, Target, & Smith, 2006; Nilsson, Svensson, Sandell, & Clinton, 2007; Rayner, Thompson, & Walsh, 2011), or even more particular features of therapist, as shown in Schnellbacher and Leijssen (2009) study about clients' perspective of therapists′ genuineness.

Research studies that specifically observed clients perspective of change or outcome have also taken place. A study conducted in Chile found that clients reported more change in successful therapies and that there is no evidence that clients and therapists agreement on change is related to good outcome (Altimir et al., 2010). Another study engaged in finding changes that clients relate to good outcome and found that participants mentioned relationships with others, symptomatic distress reduction, better self-understanding, and acceptance as the most important changes that took place in psychotherapy (Binder et al., 2010). In a recent study, participants identified that to understand the origins of the behaviors they wished to change, it was useful for them to access and explore painful experiences. Participants identified improvements in self-confidence, self-esteem, and assertiveness (Rayner et al., 2011). There are also results showing how clients' experiences of therapy do not always meet their expectations, and how this difference is tilted to pleasant surprise in good outcome or disappointment in poor outcome (Westra, Aviram, Barnes, & Angus, 2010).

The main assumption of our study is that the development of studies oriented to the professional awareness about the perspectives of the client will provide relevant data that will increase our understanding of psychotherapy and its effects. The aim of the present research is to analyze how former psychotherapy clients perceive change and how they relate that change to reason for consultation, therapeutic relationship, and termination.

About Reasons for Consultation, Therapeutic Relationship, and Therapy Termination

In a previous study (Olivera Ryberg, Braun, Balbi, & Roussos, 2011), we addressed the relationship between clients′ change perception and therapists′ interventions, and the findings suggested the need of assessing the client's explicit reason for consultation, the therapeutic relationship, and the conditions of therapy termination and their relationship with change. To reflect on "how is it that therapy works" from the clients' perspective, the current study collected data on these elements of the therapeutic process.

Reasons for Consultation

There is not much research about the role of the reason for consultation in change process or therapeutic outcome. Saunders (1993) identified four steps on the way to psychotherapy: recognizing the problem; deciding therapy might help; deciding to seek therapy; and contacting the mental health system. People who seek therapy usually have already tried to solve their problems in different ways and failed (Manthei, 2006), and when they are asked about what led them to start a therapeutic process, most clients are able to identify one or more situations they cannot cope with or a specific event that helped them make the decision (Manthei, 2006).

Therapeutic Relationship

The therapeutic relationship and its influence on psychotherapy outcome has always been of interest for psychotherapy research (Horvath & Symonds, 1991). There is enough literature on varied theoretical frameworks that support the idea that a strong therapeutic relationship is necessary for change to take place, and some authors even state it is enough for positive outcome to take place (Horvath, 2000). Several meta-analysis have shown that the concept of therapeutic alliance is a powerful predictor of therapeutic change (Flückiger, Del Re, Wampold, Symonds, & Horvath, 2012; Horvath, Del Re, Flückiger, & Symonds, 2011; Horvath & Symonds, 1991; Martin, Garske, & Davis, 2000). There are two relevant aspects of the therapeutic relationship that we have to consider for this study. On the one hand, there is evidence that clients′ perception of the quality of the alliance is a better predictor of outcome than what therapists or observers perceive (Horvath, 2000). On the other hand, most of the studies regarding therapeutic alliance engage in quantitative methodology, operationalizing the relationship with scales and inventories either for clients, therapists, or external observers (for a review see Horvath et al., 2011). The assimilation of qualitative methodology to assess how the therapeutic relationship is related to change complements the knowledge obtained by quantitative studies. At the same time, the possibility of approaching concepts such as alliance from the client's perspective facilitates the direct access to personal narratives and the phenomenological experience of such relationship (Krause, Altimir, & Horvath, 2011).

Some of the qualitative approximations to the therapeutic relationship phenomena include a study about patients' perspective of the therapeutic alliance using semistructured interviews (Bachelor, 1995). Patients' speech was classified and three types of alliance were identified: nurturing, insight-oriented, and collaborative. Patients in this sample also related strong alliance with therapists' characteristics, such as treating the client respectfully, not being judgmental, listening thoroughly, having empathy, and being trustworthy. (Bachelor, 1995) In another qualitative study, the relationship between therapeutic relationship and therapists' self disclosure was explored (Audet & Everall, 2010). The authors observed that therapist' self disclosure helps the connection between therapists and clients and engagement in therapy. In the same line of work, a synthesis on research on alliance by Krause and colleagues (2011) indicates three elements clients identify as required for the establishment of a good relationship: 1. Client must feel an affective reciprocity and emotional expressions between client and therapist, 2. Client must feel accepted, trusted, and understood by therapist, 3. Client must see therapist as someone with expertise.

Therapy Termination

Treatment abandonment and premature termination are considered one of the principal problems in psychotherapy practice (Swift & Callahan, 2011). Owing to this situation, there is an urge in studying clients' perception of their termination process and other factors associated to it. Following some pioneer work that valued the study of termination (Krebs, 1972; Marx & Gelso, 1987; Ward, 1984), in the past 15 years, there has been proliferation of empirical research toward therapists′ and clients′ perception of the termination process. Goals fulfillment, clients' dissatisfaction toward treatment, and external factors such as economy, have been identified as the principal causes of termination (Hunsley, Aubry, Verstervelt, & Vito, 1999; Renk & Dinger, 2002; Roe, Dekel, Harel, Fennig, & Fennig, 2006; Todd, Deane, & Bragdon, 2003). Researchers agree that there is a significant difference between therapists and clients in the reason they attribute termination to, clients address dissatisfaction as the primary cause for termination, while therapists have a tendency to associate treatment termination with goals fulfillment or patients' overall improvement (Hunsley et al., 1999; Todd et al., 2003).

Reasons people give for terminating their treatment have been associated to different levels of treatment satisfaction, finding that higher levels of satisfaction correlate with positive motives of termination (such as′I felt that I achieved the goals I had set′) and lower levels with negative motives (such as′I didn't trust the therapist′) (Roe, Dekel, Harel, & Fennig, 2006).

Methods

Participants

Seventeen former psychotherapy clients whose treatment had ended between 2 weeks and 6 years before the interview ($M = 20$ months) participated of this study. There were 11 women and 6 men, within an age range from 22 to 54 years, all of them lived in Buenos Aires, Argentina, and their treatments were held in outpatient independent settings. In this study, only the last treatment of each client was taken into account. For four of the participants, it was their first treatment, for five, their second, and for eight, their third ($M = 2.23$, $SD = 0.65$). The duration of those treatments ranged from 4 months to 10 years ($M = 23.82$ months, $SD = 33.5$). Frequency of sessions was typically once a week (13 cases), while two went twice a week and two went once a fortnight. Thirteen participants had university degrees, and the remaining four had completed secondary school. Although participants were not asked about occupation, interviewers did ask them if they had advanced knowledge on psychology and out of the 17 former clients, 4 were either psychologists (2) or psychology students (2).

Recruitment

The participants of the study were recruited by a snowball sampling. The members of the clinical research team directed by Dr. Roussos (four male and six female psychologists) sent mails to their acquaintances asking if they or somebody they knew had been in psychotherapy and had ended that treatment. The answers were forwarded to the first author who gathered contact information (mail and/or phones). The first author contacted the potential participants, sending information about the research (See Appendix for an example of the email potential participants received). Participants that responded to the email where then contacted by phone, and the interviewer restated the aims of the research and characteristics of their participation. Before the interview, participants signed an informed consent that specified the confidentiality of data and their right to withdraw from the research at any point. Participants also consent to publish their comments anonymously in research papers. The research was approved by the University′s Ethical Committee. After participants agreed on being part of the study, a date and time for the interview to take place was set. The interviews took place in a location chosen by the participants; most of them were held in the interviewers working place, the university were this study took place, or the participant's home. From all the people that were called (18), only one declined participation owing to time difficulties. Former clients were not contacted via therapists to reduce bias (e.g., therapist referring only clients with better outcome or clients not feeling comfortable disclosing their feelings about their therapists).

Therapists

Researchers had no contact with the therapists, nevertheless therapist's demographic information was gathered from the participants. As described by the clients, 13 therapists were men and 4 were women; among them, 8 were psychologists, 6 psychiatrists, and the remaining 3 had one of those degrees but participants were unable to identify which. Also, from the information participants reported of their therapist's framework, 12 were psychoanalists, 2 family systems, and 1 eye movement desensitization and reprocessing therapy (EMDR). There were two participants who could not provide information on this matter.

Researchers

Three trained researchers interviewed participants (women, doctoral students, whose age range was between 29 and 40 years). The analysis team was integrated by two of them plus a third researcher (man, doctoral student, 23 years old), which are the three first authors of this study. The members of the analysis team, all with consensual qualitative research (CQR) training, exchanged roles between being part of a primary team of analysis and being the auditor of the work. The fourth author of the study worked as a supervisor of the research (man, 43 years, senior researcher).

Procedures

Interview Protocol

Semistructured qualitative face-to-face interviews, lasting from 35 min to 127 min ($M = 61.29$ min; $SD = 22.90$ min) in which participants talked freely while interviewers asked opened-ended questions and pursued additional topics based on the interview protocol, were conducted. Based on the scientific questions of this study, a protocol was developed to guide the interviews. A pilot study was conducted to test the preliminary version of the protocol. Three nonparticipant volunteers, who met the participation criteria, served as testers, and then the protocol was modified. The final semistructured interview contained questions regarding the last

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psychotherapy treatment done by the participant. The guiding questions can be seen in Table 1.

Interviewers specially focused on gathering data about the way in which clients give significance to their change process and to which elements of therapy they relate them and relationships among topics were encouraged. The interviews were audio taped and then transcribed verbatim for data analysis. All the interviews and their transcriptions were stored in a safe storage place and in one of the researcher's computers, identifying participants with a code number, without including their real names. To guarantee speech fidelity, translations of client's speech were made by a bilingual researcher who is not involved in this investigation, back translations were performed by another researcher, and a final version of each statement included in this article was developed by the authors.

Data Analysis

A qualitative approach, based on CQR (Hill et al., 2005; Hill, Thompson, & Williams, 1997), was conducted to analyze the interviews. CQR is a qualitative methodology developed by psychotherapy researchers (Hill et al., 1997) for psychotherapy researchers. This method differs from other qualitative methodologies as data analysis is highly structured, and its results are based on consensus. For this study, the analyzing team followed the three main CQR steps by reaching consensus through open debate between the members of a primary team, and then between the primary team and an auditor (see Figure 1). Hill et al. (1997) state that there is no unique way of composing an analysis team. Researchers should design the team's structure according to the particular needs of their study. Hill et al. (2005) suggest three primary team members, but mention previous studies that used only two. Also, they mention that the primary team could be stable or rotating. The rotating modality used in the present research has its advantages and disadvantages. The advantages are that it avoids a repetitive analysis that may take place when the team is stable and that more point of views are represented. The disadvantage is that in rotating teams all the members do not have a full commitment with the whole data set.

In the present study, two researchers conformed the primary team and a third acted as the auditor. The three researchers involved in the analysis exchanged these roles in the different phases of the process. In each of the steps described before, the members of the primary team analyzed the transcripts of every case separately, and then discussed each case to reach consensus and create a new version. Subsequently the auditor reviewed this version and got together with the primary team to create a final document.

The steps the analysis team followed for the present study were as follows. First, the team created Domains (topic areas identified in the material) and classified all the transcriptions in those Domains. Once they finished this classification, they created core ideas (phrases abstracted from the material that synthesized the different concepts and significant meanings presented in it). Finally, within a cross-analysis, conceptual categories (grouping similar core ideas of each domain presented in different participants) were created representing common notions. The frequency of categories and the relationships among them were also analyzed. (See Figure 1 for steps of the analysis).

Results

CQR guidelines were used for establishing category frequencies (Hill et al., 2005). General categories are the ones that emerge from all or all but one cases (16/17), those emerging for more than half and up to the cutoff for general were typical (9–15), those emerging for between three and half of the cases were variant (4–8), while those with two or three cases were rare. A total of 69 categories were created, among those we found no general cate-

Table 1
Protocol Questions Related to the Domains of the Study

Domain	Questions
Perception of change	Did you perceive change due to your psychotherapeutic treatment?
	How do you think therapy affected your life?
	Were the reasons you sought therapy for addressed?
	What aspects of therapy helped you to change?
	Do you think the changes you mention could have been achieved without therapy?
	Is there something else you wish to tell me about change in your therapy?
	Was there something that did not change?
	What did your therapist do to that promoted or hindered change?
Reasons for consultation	What brought/lead you to therapy? Who?
	How did you choose your therapist?
	Where you looking for a particular type of therapist or therapy?
Therapeutic relationship	How would you describe your relationship with your therapist?
	In general, how would you describe your therapist?
	Did the relationship with the therapist change during therapy? How?
	What where the things you liked most about your therapist?
	Where there things you did not like about your therapist?
	Where there disagreements with your therapist?
	Did you have contact with your therapist between sessions?
Therapy termination	Whose idea was it to terminate therapy?
	What were the reasons behind this idea?
	How was the relationship with the therapist after therapy termination?
	Would you see this therapist again?
	What did you like the most about therapy?
	What did you dislike about therapy?

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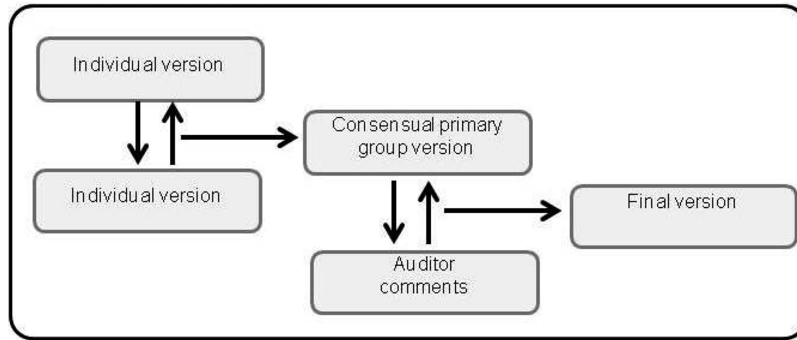

Figure 1. Steps of the data analysis.

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gories, 13 typical categories, 34 variant categories and 22 rare categories. Twenty-nine core ideas that did not match any other were also retrieved and included in "other categories" in each domain.

The main domains that were found in this study are presence or absence of change and type of change addressed (see Table 2); aspects of therapy the client relate to change and reasons for consultation (see Table 3); perception of the therapist and therapeutic relationship (see Table 4), and termination (see Table 5). The above-mentioned tables show the categories that belonged to each domain, their frequency, and an example of the core ideas that were included in each category. Also, in this section, participants′ words will be used to illustrate the categories and their interaction to bring the reader closer to the clients' phenomenological experience.

Change Perception

In the domain presence and absence of change, the categories most frequently addressed by participants were "therapy promoted change" and "change was related to reason for consultation." At the same time, categories such as "therapy did not promote change," and "during therapy there were important changes for me that did not take place" had low representation among the participants. Overall, this shows that most people of this sample perceived change in therapy and also that they found a solution for the problem that made them seek psychotherapy.

> "When I arrived to therapy everything was gray, and when therapy ended I was feeling very positive . . . I arrived with a very negative

Table 2
Domains 1 and 2, Categories and Core Ideas

Domain	Category *frequency*	Illustrative core idea
Presence or absence of change	Perceived change *Typical (15)*	Couples TH helped the C to reach a better understanding with the C partner.
	Did not perceive change *Rare (2)*	TH was a waste of time ǀ TH did not helped the C overcome a moment of crisis.
	C addressed important changes that did not take place *Variant (4)*	C says he still has hypochondriac symptoms and panic attacks.
	Change was related to RfC *Typical (14)*	TH helped the C solve the problems he/she seeked help for.
	Other categories (2)	
Type of change	Cognitive change *Typical (13)*	TH helped him/her to take a distance from 'emotions,' looking at everyday situations with more objectivity.
	Emotional change *Typical (10)*	
	Anxiety *Variant (5)*	TH helped diminishing her fear of needles.
	Mood *Variant (6)*	TH help to overcome a moment of sadness/depression state.
	Behavioral change *Variant (4)*	TH helped change the way of responding to others.
	Improve their quality of life *Typical (9)*	The C improved his/her well-being ǀ had more will to live.
	Intrapersonal change *Typical (10)*	
	Autonomy acquisition *Variant (5)*	TH helped C to take distance from his family of origin.
	Increase in self confidence *Variant (4)*	TH gave C strength, made him more confident.
	Acceptance and symptom normalization *Variant (4)*	TH helped her understand her problems did not make her 'weird'.
	Facing problematic situations *Variant (5)*	Due to TH, C has more tools to deal with problems.
	Interpersonal change *Typical (10)*	
	Family issues *Variant (6)*	C identified changes in family roles.
	Couple issues *Variant (7)*	TH enabled the C to achieve emotional closeness with her husband.
	Personality *Rare (3)*	TH helped her in her way of being.
	Being agent of personal change *Rare (2)*	TH helped him see he had the answers to solve his own problems.
	Other categories (5)	

Note. TH = therapy; C = client; T = therapist; RfC = reason for consultation.

Table 3
Domains 3 and 4, Categories and Core Ideas

Domain	Category *frequency*	Illustrative core idea
Change attribution	External factors *Rare (2)*	Pharmacotherapy was what helped her change *(another physician's prescription).*
	Talking about his/her problems *Variant (4)*	The dialogue made him change.
	Interventions *Variant (4)*	T suggestions ǀ T offered new perspectives.
	Therapist's factors (other than interventions) *Variant* (6)	T support ǀ T perspective ǀ T humorous way of expressing himself.
	Cannot identify something specific that promoted change *Rare (2)*	C cannot identify any element that made her change.
	Other categories (1)	
Reasons for consultation (Rfc)	Interpersonal problems *Typical* (10)	
	Couple issues *Variant* (7)	Evaluate a possible divorce ǀ Had difficulties with her boyfriend ǀ Had new relationship.
	Family issues *Variant* (4)	Had a bad relationship with her father.
	Emotional problems *Typical* (9)	
	Anxiety symptoms *Variant* (7)	Had frequent panic attacks.
	Mood disorder symptoms *Rare (3)*	C seeked therapy because of a depressed state.
	Grieving process *Rare (3)*	C's father's death.
	Vital crisis *Variant* (6)	C was graduating from college ǀ C was pregnant.
	Existential problems *Variant (5)*	C seeked TH in order to be enriched ǀ to understand the meaning of life.
	Significant others recommended TH *Rare (3)*	His couple's T suggested TH ǀ Their daughter's school recommended couple's TH.
	Other Categories (3)	

Note. TH = therapy; C = client; T = therapist.

> feeling, and she [the therapist] started asking questions, and with that questions she opened new compartments and as these compartments opened I was able to see new colors." (Participant 8).

Positive change was addressed more frequently than negative change, and this goes in line with Castonguay et al. (2010) where helpful events in psychotherapy were addressed more than hindering events. Only one client stated a negative change (along with other positive changes):

> "A negative change is that I smoked more cigarettes than usual during my treatment because the therapist smoked a lot and I followed his lead." (Participant 7).

The second domain, type of change, presented a large number of categories. Most frequently people mentioned cognitive change, emotional change (anxiety and mood), and behavioral change as changes that took place during treatment (see Figure 2).

> "He helped me to put a distance with my emotions, stop feeling myself as the center of the universe and perceive the situation more objectively. Enjoy more, live happier. Without that dark feeling, my whole family is very dark and psychoanalysis helped me choose the brighter side, stop complaining . . . " (Participant 14).

In terms of interpersonal (such as family or couple relationships), intrapersonal factors (such as increase in self-confidence), and quality of life, subjects addressed typically change in these categories. There is an important overlapping of these types of change perceived (see Figure 3). We can see that most people perceived change in more than one area and all the participants that perceived intrapersonal change, perceived other kinds of changes as well:

> "It was very good [the therapy], it's like, we grew as a couple and this was reflected immediately and soon my daughter changed a lot . . . Our communication and the way of solving problems, issues with the extended family . . . it was very useful, it organized me, it gave me strength. [before therapy] I didn't have the necessary tools, even though I am a psychologist! But, you know, the shoemaker's son always goes barefoot." (Participant 11).

In the third domain, "change attribution" participants pointed out three aspects of therapy as the ones that enabled change: "therapist's variables" (factors related to therapist's characteristics), "therapist's interventions", and "being able to talk about their problems" (see Table 3).

> "The best thing about therapy is that he was really paying attention to everything that happened to me. I could call (phone) him at any time of the day and he was always there, and took his time to speak to me on the phone." (Participant 4).

Reasons for Consultation

While recalling their reasons for seeking therapy, participants mentioned interpersonal problems, emotional issues such as anxiety symptoms and depression, and life crisis events (divorce, pregnancy, graduation, among others). Only a few participants stated that they went to therapy because other people suggested them they needed therapy (see Table 3).

It is interesting to observe the interaction between reason for consultation and types of change identified. For example, people that identified change in the three areas, i.e., accepting things that cannot change, being able to face their problems, or change that lead to improving their quality of life, had sought therapy for existential problems or for experiencing a crisis in their life.

> "Therapy enabled me to live lighter, without judging, without being so fussy, without wanting to have what I don't . . . Very often he [the therapist] focused on—stop feeling guilty, guilt is a Catholic and

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Table 4
Domains 5 and 6, Categories and Core Ideas

Domain	Category *frequency*	Illustrative core idea
Perception of the therapist	Positive image of the therapist *Typical (11)*	
	Therapist was idealized *Variant (5)*	T was perfect.
	The therapist inspired respect *Variant (4)*	C respected the T′s age ∣ C felt the T had a lot of experience.
	Professional background *Rare (3)*	C valued that T traveled to other countries for conventions ∣ T gave lectures.
	Preferred a male therapist *Rare (3)*	Because of her bad relationship with her father C wanted a male therapist.
	Did not find bad attitudes from T *Variant (4)*	C does not recall anything negative from T ∣ C never disagreed with T.
	Valued sharing beliefs/interests/characteristics with T *Variant (5)*	T had the same religion as C ∣ C valued T liked reading literature as herself.
	Valued T was not judgmental *Rare (2)*	C valued T did not tell him if he was doing things right or wrong.
	T did not respond to stereotypes *Rare (3)*	T did not respond to the psychoanalytic stereotype ∣ T was genuine.
	Other categories (2)	
Therapeutic relationship	Had a very good relationship *Typical (13)*	
	C felt supported *Variant (6)*	C values the support she got from T in moments of despair.
	T was trustworthy *Variant (6)*	C felt confident with T ∣ C was able to tell T things nobody knew.
	Felt disappointed/misunderstood at some point of TH *Variant (4)*	C did not agree with T criteria ∣ C felt disappointed on the third year of treatment ∣ C felt T did not understand the violence she was living at home.
	TH relationship differed from other relationships *Rare (3)*	Talking to T was different than talking to a friend ∣ T did not behave as a father would.
	There was no disagreement *Rare (3)*	C never disagreed with T ∣ T showed C other points of view, C was grateful.
	TH relationship was unstructured *Variant (4)*	C felt the relationship was natural, unstructured ∣ After termination C and T called each other.
	C and T had between session contact *Rare (2)*	C called T when feeling distressed and T sooth her by phone.
	C confronted T *Rare (2)*	C confronted T 'because T did not realize how things where for me'.
	T set limits *Rare (2)*	T was sympathetic but firm ∣ T set limits of the relationship.
	Other categories (8)	

Note. TH = therapy; C = client; T = therapist.

Jewish invention, and he laughed. That made me feel good." (Participant 14).

Therapeutic Relationship

The fifth domain, "perception of the therapist," gathers both the way subjects characterized their therapists and what they inspired to the clients. These two aspects were separated from the perception of therapeutic relationship (sixth domain), as there were many categories retrieved. As shown in Table 4, most frequently participants said they had a good image of their therapists, either they idealized him/her, respected him/her, or valued his or her professional background.

> "I found him kind, nice, simple. He was not posing, very genuine, and that was very important for me, he was not like the psychoanalytic stereotype, he was very humane." (Participant 10).

Some participants spontaneously mentioned how important it was to share personal interests or beliefs with the therapist, as well as how the therapist did not have attitudes that offended him/her.

> "He helped me a lot . . . I remember his face, his smile and that he transmitted positive energy with his face. He helped me through his good state of mind . . . he was always in good state. He listened to me and made me feel comfortable . . . there was nothing missing for him to be perfect, he listened to me, treated me kindly, gave me books to read, and also, he was catholic [the client is catholic] I felt comfortable on that issue as well." (Participant 3).

A large proportion of the sample stated they felt well with their therapist, either feeling understood, supported, or confident. At the same time, four participants expressed they have felt misunderstood or disappointed with their therapist at one point of their treatment. Some rare categories include positively valuing that their therapeutic relationship was different from other social relationships, and that there was no disagreement with their therapist. Only two participants mentioned having confronted their therapist. This domain has the largest number of individual categories (categories that only one participant mentioned); this shows the heterogeneity among the sample in terms of therapeutic relationship (see Table 4).

Figure 4 summarizes the relationship between perceived change and therapeutic relationship among the sample. It shows that the two cases that expressed they did not perceive change also expressed not having a good relationship with their therapist.

> "He was delightful but useless. Sometimes I feel like calling him to tell him that he was stupid, and on top of that the treatment was very

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Table 5
Domain 7, Categories and Core Ideas

Domain	Category *frequency*	Illustrative core idea
Therapy termination	C proposed termination *Typical (10)*	C decided to terminate because T interpretations were far fetched.
	T proposed termination *Variant (5)*	T proposed termination when C traveled went on vacations.
	C′s couple proposed termination *Rare (2)*	C′s couple had a bad image of T and decided not to pay for TH anymore.
	C and T agreed on termination *Variant (6)*	C thought it was time for termination just before T propose it himself.
	T agreed on termination *Typical (8)*	T did not show resistance when C proposed termination | T proposed termination.
	C agreed on termination *Typical (14)*	C agreed with T that TH should come to an end | C proposed termination.
	C did not agree on termination *Rare (2)*	C would have liked to continue with treatment, and was sad it finished.
	T did not agree on termination *Variant (4)*	T did not agree on TH termination and felt there were other things to work on.
	C felt T would never propose termination *Rare (2)*	C felt T would never propose termination, and it was his decision.
	Termination was abrupt *Typical (8)*	T secretary called C and told her TH would not continue.
	T offered C the possibility of contacting after termination *Variant (6)*	Although TH has finished C could call T for sessions.
	Cause for termination was reason for consultation resolution *Typical (9)*	C terminated TH because the problems she had consulted for were solved.
	Cause for termination was disappointment *Variant (6)*	C was not convinced TH was helping her.
	External causes for termination *Variant (8)*	C terminated therapy due to economic problems | because he had lost his job.
	Other Categories (8)	

Note. TH = therapy; C = client; T = therapist.

expensive. I want him to know how terrible our situation [divorce from husband] still is." (Participant 6).

> "I felt I was talking to a wall. She sat still, that's what I felt. She didn't even look at me, she kept looking down, writing stuff . . . and then one day I reached up to her door, and I said to myself: What am I doing here, I have nothing to tell to this woman, so I didn't ring the bell and left, I went home . . . I went one more time, and told her what had happened and she didn't say anything, so I thought, well she is not interested in my case so I better leave. She never called me back, so I thought, well, she is definitively not interested, and therapy ended." (Participant 16).

Therapy Termination

The last domain retrieved from the interviews was therapy termination (see Table 5). Two main categories emerged dividing the sample in two groups: the client proposed termination, and the therapist proposed termination. There is a large preponderance of participants that proposed termination, and at the same time most of the clients agreed with therapy termination even when their therapists initiated it. Another typical category was "therapy termination was due to the resolution of their reason for consultation" (see Figure 5).

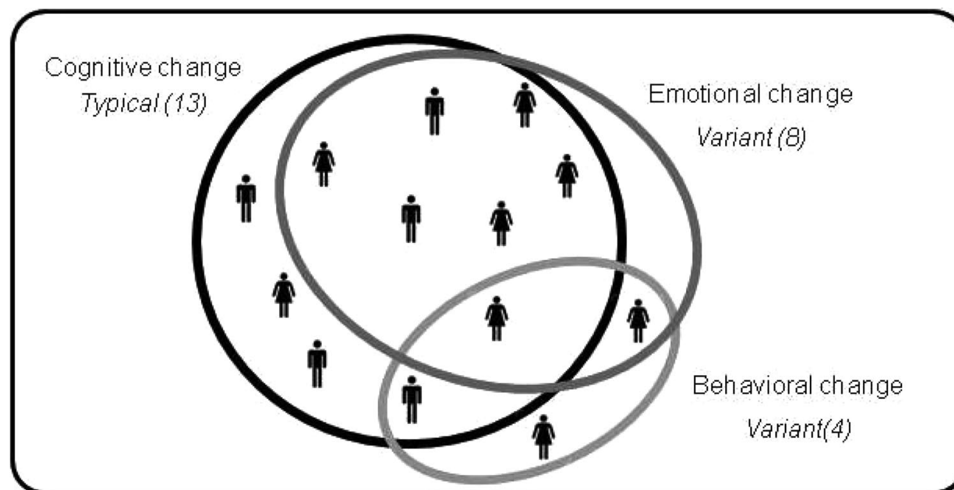

Figure 2. Types of change identified 1.

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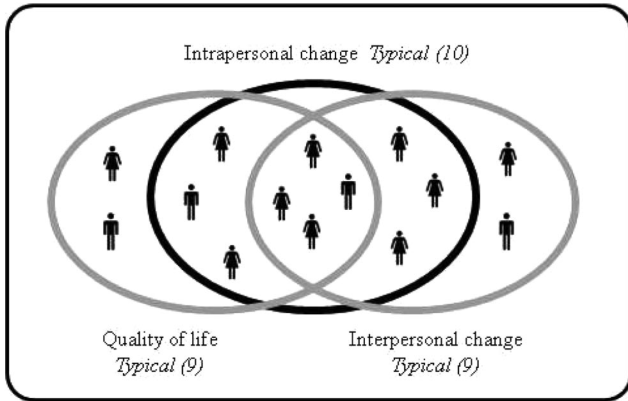

Figure 3. Types of change identified 2.

> "When I went to therapy I wanted to talk about three topics and I talked about them and I felt that I solved them . . . and in one moment therapy had become very monotonous, every Time I went I only talked about my work . . . I realized I was wasting my time . . . Finally, when I decided to terminate therapy, it was my decision, it was an unilateral decision . . . I could have been all my life with him, I felt that he was never going to tell me to end therapy, I felt that the decision to end therapy was mine." (Participant 1).

> "I felt I needed to end treatment . . . He said you can live in 1 [low] or in 10 [high], the more you analyze yourself the closer you will get to 10 . . . I told him: 'Next month I want to end therapy′ he asked me 'For any reason in particular?′ I told him that I didn't, I didn't feel like it, economic reasons, the fertility treatment. He told me: I think it's ok, the door is always open." (Participant 14).

There are some treatments that finished abruptly, either by premature termination on behalf of the client, or the therapist decided to finish treatment at the last session. Other categories that emerged but with small representation in the sample were that some clients felt the therapist would never propose termination, some clients had to finish treatment because their spouses disagreed with the therapist, and some therapists offered the client the possibility of calling him/her after termination.

Discussion

Results show that clients are able (and willing) to talk about their therapeutic experience and relate changes with this process.

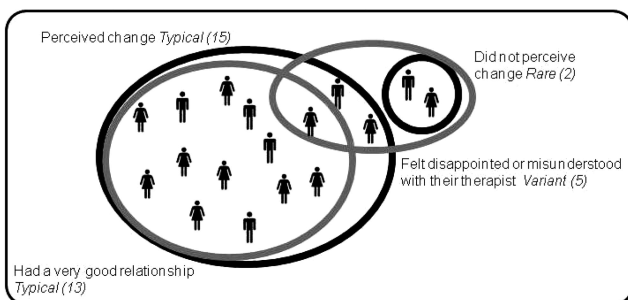

Figure 4. Change perception and therapeutic relationship.

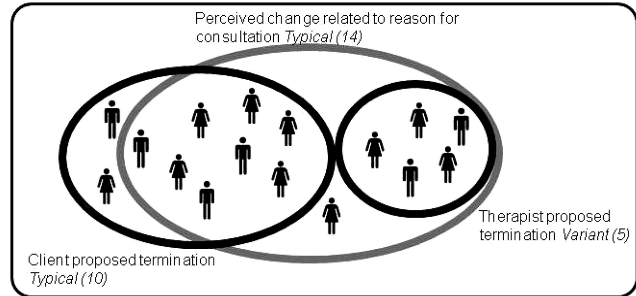

Figure 5. Termination and perceived change.

The subjects found the participation in this research motivating and some of them explicitly thanked the researchers for the opportunity of talking about their experience. Clients recalled different aspects of their experience that can be grouped in themes that are relevant for the understanding of the therapeutic process and can enrich the knowledge researchers and practitioners have of that process. Most of them show they have a clear opinion regarding their treatment and what was helpful for them, which lets us value the client's ability to identify key elements of the therapeutic process. The information coming from this source is useful to compare therapists' and clients' conceptualizations of the treatment. It is relevant for researchers to start developing strategies that integrate clients' and therapists' views, exploring differences and similarities and including both qualitative and quantitative data. This integration will enrich the current criteria about successful and unsuccessful treatments.

In the following section, we will discuss the most salient results and their clinical implications. We found that patients rarely present one area of change without mentioning other areas (see Figure 2). The overlapping of these categories raises the question of the relationship among types of change. There are several explanations for this and we present three possible ones, referring to the relationships among interpersonal change, intrapersonal change, and quality of life. As shown in Figure 6, the first hypothesis (a) is to consider that intrapersonal change (x) directly impacts on interpersonal change (y) and quality of life (y'). Another explanation (b) is that there is interdependence, where a modification in one of the areas of change (any of them) may impact on the other two. A third hypothesis (c) is that an unidentified kind of change (z) may act as confounding variable that affects the whole system. In other types of change identified, there is a prevalence of cognitive change, compared with emotional or behavioral change. This prevalence of cognitive change could elicit the same hypotheses that were mentioned in the previous situation (see Figure 6). Another explanation for this prevalence might be that cognitive changes are easier to identify and recall by clients.

Most of the participants that expressed they had changed reported a good therapeutic relationship, while two participants that did not perceive change expressed being misunderstood or disappointed with their therapist. Questions can be raised about the nature of the interaction between change and therapeutic relationship, for example, is it that they did not change because of their bad relationship? Or did they have a bad relationship because they did not perceive change? Researchers have tried to answer these questions to clarify the nature of the relationship between alliance

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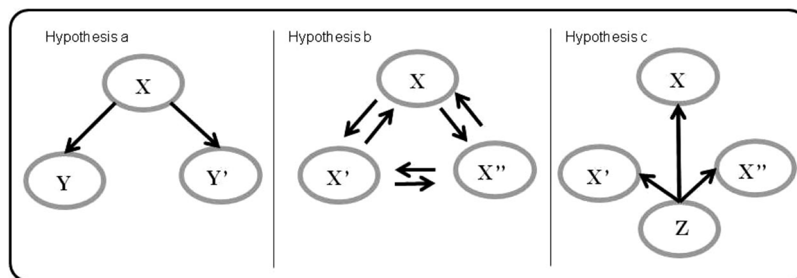

Figure 6. Hypothesis for categories overlapping.

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and change. Given the inherent difficulties regarding the manipulation of those variables results have not been conclusive. Although it has been shown that the therapeutic alliance is a moderate but robust change predictor (Horvath et al., 2011), there are authors that discuss the ability of the alliance to produce change, arguing that maybe early responses strengthen the alliance predicting positive outcome (Barber, 2009).

Another result that called our attention is that a large group of clients that promoted termination also reported the resolution of their reason for consultation. This fact makes us think about the importance clinicians give to the client's declared reason for consultation: is it possible that therapists do not assess when patients are ready to finish the treatment, do therapists not negotiate with their clients' new objectives of therapy when the initial objectives are accomplished, is it that clinicians do not take into account client's reason for consultation while designing the treatment, among other options. These results suggest that it is necessary to rethink the timing in the termination process, and how to communicate with patients about it.

The understanding of divergences and convergences among clients' and clinicians' views will facilitate the adjustment between the psychotherapeutic techniques and clients' own needs. The flow of communication amid client and therapist, in terms of how the process is perceived, might prevent reactions from the client that can derive in an alliance rupture or an early termination, and possibly will improve the quality of the relationship. Clearly, qualitative information given by the client is not intended to replace outcome measures or therapist's assessment, but should be considered as another source of information that can be valuable. Researchers′ challenge is to integrate different parts of the system, with its multiple points of view of process and outcome. Integration strategies between therapist, client, and environment ought to be attempted.

Limitations

This study has the strengths and weaknesses of most qualitative research samples, which need to be small to enable a detailed analysis. The most salient limitation of the present research is that the participants′ narratives are retrospective recalls that could be affected by their ability to remember and put the experience into words. Furthermore, time since termination of therapy varied among participants (from 2 weeks to 6 years before the interview) and this may also affect the quality and quantity of the recall.

Also, our convenience sample has limited generalizability for different reasons. First, it is culturally biased because all participants live in Buenos Aires, a city with a strong psychoanalytic tradition, where psychotherapy is widespread and available for everyone. Public hospitals offer free psychotherapeutic treatments. A study that took place in 1995 found that 25% of Buenos Aires population had undergone psychotherapy (Fernández-Álvarez, Scherb, Bregman, & García, 1995). Second, all of our sample where white, middle or high socioeconomic status, and recruited via researchers' personal contacts. Nevertheless, the generalization of our data was not an aim of this research. Instead what we sought was to generate hypotheses for research and to deepen our understanding of the phenomenological experience of our participants.

Furthermore, this research has the inherent limitations of research that uses CQR, given the interpretative element of the CQR process (Timulak, 2012, p. 274) and the use of explicit statement. In addition, authors that developed CQR analysis recommend questions to be asked in the same way for all the participants (Hill, Thompson, Williams, 1997), and in this study, the interview protocol did not follow these guidelines. Client′s perception is biased, nevertheless a client′s perception of how their therapy is doing and their change process will guide him/her on decisions about whether to continue their treatment or terminate it.

Further Research

When we planned this research, we chose to interview participants that had ended therapy because we were concerned about interfering in the therapeutic process. Our hypothesis, that needs more investigation, is that asking open questions to someone during therapy may provoke insights in the client that could facilitate or hinder the therapeutic process. More research needs to be done to determine the detrimental or beneficial effects of different types of questions and different interviewers.

It would be also interesting to perform research comparing clients' and therapists' retrospective account of change. Additional research could also incorporate clients' diagnosis, therapists′ theoretical framework, outcome measures used in the treatment, and other information that could help broaden our understanding by integrating clients′ accounts with information from other sources. This kind of study should be continued to provide useful information to clinicians in terms of what elements of the therapeutic process they should share with their patients and perhaps discuss with them.

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Appendix

Participant Invitation Letter

Hello (participant's name),

My name is XXX and I am doctoral student conducting research funded by CONICET. I am studying client's perspective of the change process in therapy. I am sending you this email because XXX (name of the person who provided contact information) told me you had undergone therapy. For this research I need to perform an interview about your experience of therapy. The interviewers are psychologists who have been trained for this research. During the interview questions about your experience in psychotherapy will be asked, but there is no need to talk about private aspects of your life. The interview will focus on your experience as a patient and not on the issues that you were working on in therapy. The interview should take about 90 minutes and will be audio-recorded. The information gathered during the interview will remain confidential, no information will enable to link the person participating with what they say during the interview. The name of the therapist will not be asked and you may decline to answer any question if you wish to do so. The place and time of the interview will be decided according to your preferences. If you have any questions you can contact me via email or at my phone XXX or XXX at XXX.

If you agree to participate, please respond to this email sending a contact telephone number and an interviewer will contact you to arrange the time and place of the interview. If at any time during the interview or after you should want to decline your participation you may do so and the recording will be destroyed.

Thank You Very Much

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